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INSURANCE

DEPARTMENT OF BANKING AND INSURANCE

DIVISION OF INSURANCE

Managed Care Plans

Provider Networks

Proposed Amendments: N.J.A.C. 11:4-37.4; 11:22-4.2, 4.3, 4.4, and 4.5; 11:24-15.2; 11:24A-4.15; 11:24B-5.2; and 11:24C-1.3

Proposed New Rules: N.J.A.C. 11:24C-4

Proposed Repeals: N.J.A.C. 11:24B-5.8, 5.9, and 5.10

Authorized By: Thomas B. Considine, Commissioner, Department of Banking and Insurance.

Authority: N.J.S.A. 17:1-8.1, 17:1-15e, 26:2S-1 et seq., and 17B:30-1 et seq.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2012-036.

Submit comments by April 21, 2012 to:

Robert J. Melillo, Chief

Legislative and Regulatory Affairs

New Jersey Department of Banking and Insurance

20 West State Street

PO Box 325

Trenton, NJ 08625-0325

Fax: (609) 292-0896

Email: legsregs@dobi.state.nj.us

The agency proposal follows:

Summary

The Department of Banking and Insurance (Department) has received a number of complaints regarding various aspects of the administration of health plan provider networks. These include access to network pricing; concerns about the timeliness of credentialing new network participants; the accuracy of network status described in provider directories; carriers using regulatory filing requirements as a pretense for not agreeing to desired contract terms; carriers "leasing" their networks to third parties without any ability of a participating provider to identify a patient to a carrier contract; carriers unilaterally making changes during the term of the contract which affect terms previously negotiated; and carriers unilaterally making other adverse changes during the term of a contract without providing an avenue for termination or rejection of the change.

Among the responsibilities of the Department is protecting consumers while promoting the growth, financial stability, and efficiency of the insurance industry. Efficient operation of health insurance plans requires that:

- Consumers and providers receive and have access to timely and accurate information on the network status of health care providers, both as they join and as they leave health plan networks;

- Providers and health plans have maximum freedom to reach mutually acceptable terms of participation, without undue regulatory burden;
- Material terms of participation are available to prospective and current network providers;
- Contracts are administered according to their terms, without the ability of either party to unilaterally change their own responsibilities while holding the other party to fixed responsibilities;
- Non-exclusive contracts between two parties neither inhibit nor control the terms of contracts with third parties; and
- Contracts that may be extended to other payers expressly so provide, and providers have information on who may access their contract.

Accordingly, the Department's proposal includes the following:

N.J.A.C. 11:4-37, Selective Contracting Arrangements of Insurers, is being amended to add a provision at N.J.A.C. 11:4-37.4(f) requiring carriers that contract directly with network providers to comply with the requirements of the new provider network rules being proposed concurrently at N.J.A.C. 11:24C-4.

N.J.A.C. 11:22-4, the Department's organized delivery systems (ODS) rules relating to entities seeking to become licensed ODSs, are being amended at N.J.A.C. 11:22-4.2, 4.3, 4.4, and 4.5 to remove all references to the Department of Health and Senior Services (DHSS). Reorganization Plan No. 005-2005 transferred all of the DHSS's Office of Managed Care functions to the Department and incorporated DHSS's rules into the Department's rules in Title 11 of the New Jersey Administrative Code.

Accordingly, the references requiring the Department to consult with the DHSS are no longer needed. This chapter is also being amended to add language to N.J.A.C. 11:22-4.5(b)4 requiring that the standard forms of provider agreements used by ODSs comply with the requirements of the new provider networks rules being proposed at N.J.A.C. 11:24C-4 and with the organized delivery system rules on certification and review of license applications at N.J.A.C. 11:24B-2.

N.J.A.C. 11:24, the Department's health maintenance organizations (HMO) rules, are being amended at N.J.A.C. 11:24-15.2(h) to require all provider contracts with HMOs to comply with the requirements of the new provider networks rules being proposed at N.J.A.C. 11:24C-4.

N.J.A.C. 11:24A, the Department's Health Care Quality Act (HCQA) application to insurance companies, health service corporations, hospital service corporations, and medical service corporations rules, are being amended to require that all provider contracts of such entities comply with the new rules being proposed at N.J.A.C. 11:24C-4. N.J.A.C. 11:24A-4.15 is being amended to delete the requirement that the form(s) of provider agreements, and any amendments thereto, are to be submitted to the Department for prior approval.

N.J.A.C. 11:24B, the Department's organized delivery systems rules relating to entities seeking to become certified as ODSs, are being amended because some of the requirements contained therein that relate to provider agreements are being replaced by the new rules being proposed at N.J.A.C. 11:24C-4. N.J.A.C. 11:24B-5.2(a) is being amended to require that all provider agreements with ODSs comply with the new rules

being proposed at N.J.A.C. 11:24C-4. Additionally, the current requirements set forth at N.J.A.C. 11:24B-5.2(a)1, which state that provider contracts and amendments must be subject to the Department's prior approval and that certain types of amendments do not require prior approval, are being deleted, and replaced with a new provision at N.J.A.C. 11:24C-4.3(a) that does not require prior approval of provider agreements unless otherwise provided by statute. N.J.A.C. 11:24B-5.2(a)2 is being recodified as paragraph (a)1. Current N.J.A.C. 11:24B-5.2(a)3, which contains notice requirements for amendments to provider contracts, is being deleted and replaced with new requirements at N.J.A.C. 11:24C-4.3(c). N.J.A.C. 11:24B-5.2(a)4 through 21 are being recodified as paragraphs (a)2 through 18. Current N.J.A.C. 11:24B-5.8 through 5.10, which contain additional requirements related to provider agreements, are being repealed.

N.J.A.C. 11:24C-1, the Department’s physician credentialing rules for managed care plans, is being amended to add a new subsection at N.J.A.C. 11:24C-1.3(a) containing standards and procedures for the credentialing application process. The Department notes that both providers and carriers have shared responsibilities for quick and efficient credentialing processes. Accordingly, the proposal provides that for providers using the Council for Affordable Quality Healthcare (CAQH) Universal Provider Datasource, carriers shall complete the credentialing process within 90 days. The amendment also includes timeframes and procedures for such carriers to notify an applicant of an incomplete application and for an applicant to correct any deficiencies in the application. A new subsection (b) is being proposed, which requires carriers to

follow the credentialing timing requirements set forth at N.J.A.C. 11:24-3.9 and N.J.A.C. 11:24A-4.7 for providers not using the CAQH Universal Provider Datasource.

Proposed new N.J.A.C. 11:24C-4.1 contains the purpose and scope of the proposed new provider networks rules that establish standards relating to agreements entered into by carriers and health care providers. This section exempts from the rules' requirements those contracts entered into between a carrier and Medicaid to provide Medicaid Only coverage and NJ FamilyCare coverage.

Proposed new N.J.A.C. 11:24C-4.2 contains definitions of terms used throughout the subchapter.

Proposed new N.J.A.C. 11:24C-4.3 addresses various issues relating to provider agreements with carriers. Unless otherwise required by statute, provider agreements will not be subject to the Department's prior approval. For provider agreements for which fees are not individually negotiated, this section requires a carrier to make available to network providers and prospective network providers all complete fee schedule(s) that are or are to be included in their agreement. These fee schedules must be provided in writing unless the carrier makes the fees for included CPT or HCPCS codes available on their website or through another electronic medium. This section also requires that when a provider is contemplating participating in multiple health benefits plans offered by a carrier with different fee schedules, the carrier must provide the complete proposed fee schedule for each plan in which the provider participates. This section also requires the carrier to make available online the name of any commercially available software it uses for editing claims, along with a description

of carrier-specific edits, in a manner detailed enough to provide an understanding of such specific edits.

This section further establishes certain criteria that all provider network agreements must meet. This section prohibits the inclusion of "most favored nation" clauses in agreements, as that term is defined in the proposed new rules. This section requires any agreement that permits unilateral changes to provide that material terms shall only be revised with sufficient advance notice to permit termination in advance of the effective date of the change. If the terms of an agreement have been the subject of negotiation, no changes can be made unilaterally to the administration of the contract materially impacting those terms. This section also prohibits a carrier from making available the terms of a provider agreement to any third party unless certain conditions as set forth in these rules are met.

This section further permits an adverse change or amendment to be made during the term of the agreement, but only in accordance with the terms of the agreement and upon 90 days notice prior to the effective date of the change or amendment. If the provider declines to accept the amendment, the provider may terminate the agreement pursuant to the terms set forth at N.J.A.C. 11:24C-4.3(c)3. This section also permits agreements to automatically renew, but no adverse change may be made to its terms upon automatic renewal. Any change that is to be made must be done so as set forth in this section. Finally, this section requires carriers to deliver to participating providers a copy of the fully executed initial agreement and any amendments thereto within 30 days after the effective date of the initial or amended

agreement, and within 30 days after the date of a request from the provider for a copy of the agreement and/or amendments.

Proposed new N.J.A.C. 11:24C-4.4 addresses provider reimbursement, and requires that when participating providers are reimbursed on a basis other than fee-for-service, the agreement must specify the dollar amount or formula used by the carrier to determine reimbursement, and identify the services included in and excluded from the alternate reimbursement methodology.

Proposed new N.J.A.C. 11:24C-4.5 contains content and availability requirements related to the carriers' provider network directories. The Department believes that up-to-date provider network directories are essential for consumers to have reliable and current information regarding the healthcare providers participating in a particular network at any given time. The Department is also aware that networks are constantly changing, making it difficult for carriers to maintain accurate directories at all times. Accordingly, the Department believes that rules are needed to address this issue and establish common, enforceable standards for network directories in order for directories to be more reliable and less likely to mislead consumers contemplating joining a network-based health benefits plan or when they attempt to obtain in-network healthcare services and supplies. This section requires that carriers maintain and make available provider network directories. The directories must contain accurate and current information on all participating providers and must include specific information about each provider. In addition to containing a listing of the carrier's in-network hospital facilities, directories must also include a listing of the carrier's in-network

hospital outpatient facilities, and a statement advising members that not all outpatient service providers located at in-network hospitals are in-network providers. This section requires a carrier's electronic directory to include functions designed to facilitate the ability of members to customize their search for providers, including, but not limited to, search functions for specialty and geographic area.

Carriers are required to deliver, upon request, their current printed directory to members and prospective members of the carrier's health benefits plans. These requirements may be complied with by printing and mailing the most current version of the on-line directory applicable to a particular member's plan rather than periodically publishing and stocking hard copy directories. The carrier must mail a copy of the printed directory within five business days of the request. Published directories must accurately reflect the content of the carrier's electronic directory as of the date the directory was submitted for publication, and certain information set forth in these proposed rules must be included in or accompany the printed directory. Carriers are required to maintain a history of their electronic directories and any printed directories for three years.

Proposed new N.J.A.C. 11:24C-4.6 contains standards for accuracy of provider directory information. This section requires carriers to implement a system for maintaining accurate and current information on all providers listed in a network directory. Carriers must also ensure that the information in the directory is based on the most recently submitted information from the provider or the CAQH. This section also contains requirements regarding carriers' updating of electronic directories and

procedures the carrier must follow if disputing a notice that information on a provider is inaccurate. Carriers are required to confirm the participation of any provider who has not submitted a claim for a 12-month period or otherwise communicated with the carrier in a manner evidencing the provider's intention to continue to participate in the network and for whom no change in provider status has been reported by CAQH by following the procedure set forth in this section.

As a 60-day comment period is provided for this notice of proposal pursuant to N.J.A.C. 1:30-3.3(a)5, this notice is not subject to the provisions of N.J.A.C. 1:30-3.1 and 3.2 governing rulemaking calendars.

Social Impact

These proposed new rules, repeals, and amendments will have a positive impact on all providers and carriers entering into network agreements, as well as an indirect positive impact on covered persons. Because the proposed new rules, repeals, and amendments address many concerns of providers related to the negotiation and implementation of their agreements with carriers, the Department anticipates that providers will be more willing to enter into or remain a party to such agreements, thereby making network-based health benefits plans more comprehensive and their networks of participating providers more stable. This, in turn, will support efforts to contain the costs of health care and health insurance and to reduce the uncertainty, anxiety and inconvenience that consumers frequently experience as a result of decisions by providers to leave network-based plans or curtail the extent to which they participate in such plans. Consumers will also benefit because the proposed network directory

requirements will facilitate the process of identifying and locating network providers that will meet their individual healthcare needs. Carriers will experience a reduction in the number of complaints received from providers related to the issues addressed in the proposed new rules and amendments.

Economic Impact

These proposed new rules, repeals, and amendments will have a favorable impact on carriers, providers, and consumers. As mentioned above in the Social Impact statement, it is anticipated that the adoption of these proposed new rules, repeals, and amendments will result in an increasing number of providers being willing to enter into or remain a party to provider agreements with carriers. This increased participation in provider networks will result in more stable and comprehensive networks.

Carriers will benefit because they will be able to pay a greater number of providers at an in-network standard or negotiated rate, thereby reducing their costs. Consumers will ultimately benefit because the cost savings experienced by carriers will be passed along to them in the form of lower health coverage premiums.

Providers also will be favorably impacted economically. Because the proposed rules require carriers to complete all provider credentialing within 90 days of the provider's submission of an application from providers using the CAQH Universal Credentialing Datasource, providers will be able to join a network and receive reimbursement as a network provider without undue delay. Providers will also benefit from the requirement that any dollar amount or methodology used for paying providers on a basis other than fee-for-service be included as part of the agreement. This

requirement will give providers advance knowledge of the payment amounts they can expect to receive from carriers for the services they render, as well as reasonable assurance that they will actually receive those amounts.

Providers will also be favorably impacted economically by the prohibition upon the inclusion in agreements of “most favored nation” clauses because they will be free to negotiate advantageous terms with all plans. Providers may also benefit economically from the provider network directory requirements because consumers will have up-to-date information concerning network providers, which may result in an increase in the number of patients for some providers.

Carriers may initially incur some increased administrative costs, but only to the extent that they do not currently perform the requirements imposed by these new rules and amendments.

These rules require carriers to deliver to providers a complete agreement, including fee schedules; carriers may automatically renew agreements, but no adverse change may be made to the terms of the agreement unless 90 days' notice is given to the provider, and the provider may decline to accept the renewal agreement and terminate the agreement; carriers must disclose the dollar amount or methodology used for reimbursement in the agreement if providers are paid on a basis other than fee-for-service. Accordingly, carriers may not reimburse providers at a rate different from that which the providers reasonably anticipated receiving based upon the previously agreed upon fee schedule or formula. The rules’ prohibition on “most favored nation” clauses and clauses having a similar effect may negatively impact carriers commanding

sufficient market share to demand such clauses because such carriers will not be permitted to reimburse providers at a lower rate than the one contracted for by the provider by invoking a most favored nation clause. It may also positively impact other carriers who will be able to negotiate without the constraints imposed on providers by other carriers.

Carriers will experience an additional negative economic impact to the extent they do not currently perform, or have not committed to perform, the requirements imposed by these new rules and amendments. However, by having clear, enforceable rules prescribing the standards applicable to provider agreements that should improve long-term network stability and benefit all market participants, these initial costs will be outweighed.

Federal Standards Statement

A Federal standards analysis is not required because the Department's proposed new rules, repeals, and amendments addressing provider network agreements entered into by health care providers and carriers are not subject to any Federal standards or requirements.

Jobs Impact

The Department does not anticipate that these proposed new rules, repeals, and amendments will result in the generation or loss of jobs.

Agriculture Industry Impact

The proposed new rules, repeals, and amendments will have no agriculture industry impact.

Regulatory Flexibility Analysis

Some carriers and providers required to comply with these proposed new rules and amendments may be "small businesses" as that term is defined at N.J.S.A. 52:14B-16 et seq. Further, the proposed new rules and amendments include numerous reporting, recordkeeping, and compliance requirements as set forth in the Summary above. Carrier requirements include, but are not limited to, completing provider credentialing within specific timeframes; delivering provider agreements and fee schedules to providers within specific timeframes; following a specific process within certain timeframes for amending and renewing provider agreements; excluding most favored nation type clauses in provider agreements; implementing a system for maintaining accurate and current information on all providers listed in a network directory; maintaining a history of their electronic directories and retaining copies of any written directories for at least three years; and confirming the continuing participation of network providers.

While these requirements impose certain administrative and recordkeeping responsibilities on carriers who enter into agreements with carriers, it is unlikely that the requirements will necessitate any additional professional services. The attendant cost to carriers for complying with these requirements is discussed above in the Economic Impact statement. The proposed new rules and amendments do not establish differing compliance or reporting requirements or timetables applicable to

small business carriers or exempt them from any of the requirements. However, as stated in the Summary above, the purpose of these new rules, repeals, and amendments is to resolve some significant issues related to the terms and conditions to which providers must frequently agree in order to join carriers' provider networks. If left unresolved, those terms and conditions will negatively impact the development and maintenance of provider networks and consequently, the delivery of health care in the State. Accordingly, the Department believes that these new rules and amendments must be applied uniformly. Therefore, no exemption from, or relaxation of, the requirements is made based on carrier size.

Housing Affordability Impact Analysis

The proposed amendments, repeals, and new rules will have no impact on housing affordability. The amendments, repeals, and new rules affect managed health care plans.

Smart Growth Development Impact Analysis

The proposed amendments, repeals, and new rules will have no impact on housing production in Planning Areas 1 or 2, or within designated centers, under the State Development and Redevelopment Plan. The proposed amendments, repeals, and new rules affect managed health care plans.

Full text of the rules proposed for repeal may be found in the New Jersey Administrative Code at N.J.A.C. 11:24B-5.8, 5.9, and 5.10.

Full text of the proposed amendments and new rules follows (additions indicated in boldface **thus;** deletions indicated in brackets [thus]):

CHAPTER 4

ACTUARIAL SERVICES

SUBCHAPTER 37. SELECTIVE CONTRACTING ARRANGEMENTS OF INSURERS

11:4-37.4 Selective contracting arrangement approval and amendment procedures

(a) - (e) (No change.)

(f) In addition to the requirements set forth in this section, a carrier contracting directly with network providers shall comply with the requirements set forth at N.J.A.C. 11:24C-4.

CHAPTER 22

HEALTH BENEFIT PLANS

SUBCHAPTER 4. ORGANIZED DELIVERY SYSTEMS

11:22-4.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

. . .

[“DHSS” means the New Jersey Department of Health and Senior Services.]

. . .

11:22-4.3 License requirement

(a) - (b) (No change.)

(c) An organized delivery system that is granted an exemption from licensure shall apply to and obtain certification as an organized delivery system from the [DHSS] **Department** pursuant to N.J.S.A. 17:48H-1 et seq.

(d) (No change.)

11:22-4.4 Application procedures

(a) An application for a license to operate an organized delivery system shall be filed with the Commissioner, and shall contain a completed application, containing the information and in the format set forth in Exhibit A in the Appendix to this subchapter, incorporated herein by reference. In addition, the application shall be accompanied by:

1. (No change.)

2. Any additional information as may be required from a particular applicant by the Commissioner [or the Commissioner of DHSS].

(b) (No change.)

11:22-4.5 Application review procedures

(a) The Commissioner[, in consultation with the Commissioner of DHSS,] shall review an application for licensure and notify the applicant of any deficiencies contained therein within 60 days of receipt. An applicant shall address any deficiencies in its application within 60 days of notice thereof.

(b) Upon receipt and review of a complete application that contains all of the information set forth in N.J.A.C. 11:22-4.4, the Commissioner shall issue a license to an organized delivery system if he or she finds that the system meets the following standards:

1. – 3. (No change.)

4. The standard forms of provider agreements to be used by the organized delivery system are acceptable**, and comply with all requirements set forth at N.J.A.C. 11:24C-4 and 11:24B-2**;

5. – 8. (No change.)

(c) - (d) (No change.)

[(e) The Commissioner shall refer all standard forms of provider agreements, quality assurance programs and utilization management programs to be used by the organized delivery system to the Commissioner of DHSS for review pursuant to standards and requirements established by DHSS. The Commissioner shall consult with the Commissioner of DHSS regarding provider agreements, quality assurance programs and utilization management programs in determining whether the applicant for a license:

1. Has demonstrated the potential ability to assure that health care services will be provided in a manner that will assure the availability and accessibility of the services;

2. Has adequate arrangements for an ongoing quality assurance program, where applicable;

3. Has established acceptable forms for provider agreements to be used by the system; and

4. Has demonstrated that the persons who are to perform the health care services are properly qualified.]

[(f)]**(e)** The Commissioner[,in consultation with the Commissioner of DHSS,] may deny an application for a license if the applicant fails to meet any of the standards provided in this subchapter or on any other reasonable grounds. If the license is denied, the Commissioner shall notify the applicant and shall set forth the reasons for the denial in writing. An existing organized delivery system seeking licensure whose application is denied may request a hearing by notice to the Commissioner within 30 days of receiving the notice of denial. The hearing shall be conducted in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and 52:14F-1 et seq., and Uniform Administrative Procedure Rules, N.J.A.C. 1:1. Upon such denial, the applicant shall submit to the Commissioner a plan for bringing the organized delivery system into compliance or providing for the closing of its business.

CHAPTER 24

HEALTH MAINTENANCE ORGANIZATIONS

SUBCHAPTER 15. PROVIDER AGREEMENTS AND RISK TRANSFERENCE

11:24-15.2 Minimum standards for provider agreements

(a) - (g) (No change.)

(h) In addition to the requirements set forth in this section, all provider contracts with the HMO shall comply with the requirements set forth at N.J.A.C. 11:24C-4.

CHAPTER 24A

HEALTH CARE QUALITY ACT APPLICATION TO INSURANCE COMPANIES, HEALTH SERVICE CORPORATIONS, HOSPITAL SERVICE CORPORATIONS, AND MEDICAL SERVICE CORPORATIONS

SUBCHAPTER 4. PROVISIONS APPLICABLE TO CARRIERS OFFERING ONE OR MORE HEALTH BENEFITS PLANS THAT ARE MANAGED CARE PLANS

11:24A-4.15 Minimum standards for provider contracts

(a) (No change.)

(b) In addition to complying with N.J.A.C. 11:4-37 **and 11:24C-4**, all provider contracts shall specify:

1. – 11. (No change.)

(c) - (e) (No change.)

[(f) The form(s) of the provider agreements, and any amendments thereto, shall be submitted to the Department for prior approval.]

CHAPTER 24B

ORGANIZED DELIVERY SYSTEMS

SUBCHAPTER 5. PROVIDER AGREEMENTS

11:24B-5.2 General provisions

(a) All provider agreement forms shall **comply with the requirements set forth at N.J.A.C. 11:24C-4 and shall** contain:

[1. A provision specifying that the contract and amendments thereto are subject to prior approval of the Department, and may not be effectuated without such approval.

i. The provision may state the following types of amendments do not require prior approval of the Department:

(1) Amendments that are of a clerical nature;

(2) Amendments that alter numbers, be they dollar amounts, enrollment amounts or the like, without altering methodologies from which the numbers were derived; and

(3) Amendments that involve the substation of one set of variable text for another set of variable text, if both sets of variable text were previously approved by the Department for the provider agreement form;]

[2.] **1.** (No change in text.)

[3. A provision specifying the number of days or months required by all parties to the contract to provide notice of amendments to the contract.

i. The prior notice required for an ODS to provide notice to a provider shall not be less than 30 calendar days.

ii. The provision shall include an exception to the required notice standards to accommodate more immediate changes that may be required by State or Federal law.

iii. The provision may include an exception to the required notice standards for changes that are not material, but only if the term “material” is defined in the contract.]

[4.] **2.** A provision specifying the compensation methodology.

i. – iii. (No change.)

iv. Notwithstanding (a)[4i]**2i** above, capitation shall not be the sole method of reimbursement to providers that primarily provide supplies (for instance, prescription drugs or durable medical equipment) rather than services.

v. (No change.)

Recodify existing 5. – 21. as **3. – 18.** (No change in text.)

(b) – (d) (No change.)

CHAPTER 24C

MANAGED CARE PLANS

SUBCHAPTER 1. PHYSICIAN CREDENTIALING

11:24C-1.3 Credentialing standards

(a) For providers using the Council for Affordable Quality Healthcare (CAQH) Universal Provider Datasource, carriers shall complete provider

credentialing within 90 days of receipt of a complete credentialing application in accordance with this subchapter.

1. Within 45 days of a carrier's receipt of notice from CAQH of an applicant's credentialing application, a carrier shall notify the applicant whether the application is complete or incomplete. If the application contained an e-mail address, the carrier may provide the notice electronically. If the application did not contain an e-mail address, the carrier shall provide the notice in writing. If an application is incomplete, the notice shall identify all deficiencies and specify all additional information required to be submitted by third parties and, if applicable, by the applicant in order for the application to be considered complete. The notice shall also specify the due date for receipt of any additional information required from the applicant.

2. The notice referenced in (a)1 above shall include the phone number and e-mail address of the carrier's department responsible for accepting the information required to complete the application and for providing assistance regarding the carrier's credentialing process and the status of a credentialing application. Carriers shall respond to all credentialing inquiries within five business days.

(b) For providers not using the CAQH Universal Credentialing Datasource, carrier credentialing timing requirements shall be as stated in N.J.A.C. 11:24-3.9 and 11:24A-4.7.

Recodify existing (a) - (b) as **(c) - (d)** (No change in text.)

[(c)] **(e)** As an alternative to the requirements set forth in [(a) or (b)] **(c) or (d)** above, carriers may access information about a physician from a recognized, national credentialing database, data bank or repository of health care providers subject to the following conditions:

1. Carriers shall not require providers to use a national database in lieu of one of the forms set forth in [(a) or (b)] **(c) or (d) above** in order to participate in the carrier's network(s).

2. – 9. (No change.)

10. Nothing set forth in this subsection shall preclude a carrier from consulting a national database to verify data submitted in accordance with [subsection (a) or (b)] **(c) or (d) above**.

SUBCHAPTER 4. PROVIDER NETWORKS

11:24C-4.1 Purpose and scope

(a) The purpose of this subchapter is to establish standards relating to agreements entered into between carriers and health care providers.

(b) This subchapter shall apply to all insurance companies, health service corporations, hospital service corporations, medical service corporations, and health maintenance organizations (HMOs) authorized to issue health benefits plans in this State and to organized delivery systems (ODSs). This subchapter shall not apply to those contracts entered into

between a carrier and Medicaid to provide Medicaid Only coverage or NJ FamilyCare coverage.

(c) On and after the operative date of its adoption, this subchapter shall apply to all newly entered agreements and all renewals of previously existing agreements.

11:24C-4.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise:

"Adverse change" or "adverse amendment" means any action taken by a carrier that that could reasonably be expected to have a material adverse impact on either the aggregate level of payment to a health care provider or the administrative expenses incurred by the provider in complying with the change. Examples include, but are not limited to, a carrier's discontinuance of reimbursement for a particular service (CPT or HCPCS code); a carrier's refusal to pay, or payment of decreased reimbursement, based on the location of service or professional designation of the individual providing the service; or the imposition of a prior certification requirement for a category of services performed within that provider's practice. An adverse change shall not include:

1. Fee schedule changes attributable to a third party and over which the carrier has no control (for example, the Medicare fee schedule);

2. Changes made as a result of changes in provider billing practices, such as an increase in a facility's Charge Master; and

3. Changes resulting from the introduction of, discontinuance of, or changed usage of a CPT code, HCPCS code, or modifier by the American Medical Association or the Centers for Medicare & Medicaid Services.

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation, and health maintenance organization authorized to issue health benefits plans in this State. "Carrier" also includes organized delivery systems as defined in N.J.A.C. 11:22-4.2 and 11:24B-1.2.

"Commissioner" means the Commissioner of the Department of Banking and Insurance.

"CPT code" means the American Medical Association's current procedural terminology code.

"Department" means the Department of Banking and Insurance.

"Edit" means a practice or procedure pursuant to which one or more adjustments are made by the carrier to CPT codes or HCPCS codes included in a claim that result in:

1. Payment being made based on some, but not all, of the CPT codes or HCPCS codes included in the claim;

2. Payment being made based on different CPT codes or HCPCS codes than those included in the claim;

3. Payment for one or more of the CPT codes or HCPCS codes included in the claim being reduced by application of Multiple Procedure Logic;

4. Payment for one or more of the CPT codes or HCPCS codes being denied; or

5. Any combination of 1 through 4 above.

"Fee schedule" means the complete fee schedule that is applicable to and will be a part of an existing or contemplated provider agreement with a contracting provider.

"HCPCS code" means the Centers for Medicare & Medicaid Services Healthcare Common Procedure Coding System code.

"Health benefits plan" means a hospital and medical expense insurance policy; health service corporation contract; hospital service corporation contract; medical service corporation contract; health maintenance organization subscriber contract; or other plan for medical care delivered or issued for delivery in this State. For purposes of this subchapter, health benefits plan shall not include one or more, or any combination, of the following: coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only

insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health benefits plans shall not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in Federal regulations. Health benefits plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor. Health benefits plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the Federal Social Security Act (42 U.S.C. § 1395ss(g)(1)); and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (10 U.S.C. §§ 1071 et seq.); and similar supplemental coverage provided under a group health plan.

"Health care provider" or "provider" means an individual or entity that, acting within the scope of its license or certification, provides a covered service or supply as defined by the health benefits plan. Health care provider includes, but is not limited to, a physician or other health care professional licensed pursuant to Title 45 of the Revised Statutes, and a hospital or other health care facility licensed pursuant to Title 26 of the Revised Statutes.

"Most favored nation clause" means any clause in a provider agreement that requires the provider to maintain or reduce the rate specified in the agreement based upon a lower rate the provider has accepted or has agreed to accept from a third party(ies) for providing the same or a comparable service or supply.

"Multiple Procedure Logic" means the practices or procedures used by a carrier to reduce the allowable amount for one or more of the CPT codes or HCPCS codes included in a claim as a result of multiple surgical procedures or multiple services having been performed on the same patient on the same date of service.

"Participating provider" means a provider who is a party to a provider agreement with a carrier.

"Practice limitation" means any restriction a provider imposes on his or her practice that affects the access of covered persons to his or her services including, but not limited to, treating only persons who are confined to a hospital or other institution, treating only persons of certain ages, refusing

new patients at certain office locations, and refusing to perform certain procedures (for example, obstetrician/gynecologists who will not perform deliveries).

"Provider agreement" or "agreement" means a contract between a carrier and a provider, or between a carrier and another entity pursuant to which the provider is covered, and under the terms of which the carrier agrees to pay the provider for, and the provider agrees to provide covered health care services or supplies to persons covered by a health benefits plan issued by the carrier. "Provider agreement" or "agreement" includes the agreement, any fee schedule that is part of the agreement, and any appendices, attachments or amendments to the agreement.

11:24C-4.3 Provider agreements

(a) Unless otherwise provided by statute and except as set forth in this section, no agreement between a participating provider and a carrier shall be subject to prior approval by the Commissioner. In the case of HMOs, only the proposed form of provider agreement submitted to the Department with the HMO's initial application for a certificate of authority pursuant to N.J.S.A. 26:2J-3 shall be subject to prior approval by the Commissioner.

(b) For provider agreements for which fees are not individually negotiated, carriers shall make available to network providers and prospective network providers all complete fee schedule(s) that are or are to

be included in their agreement. Fee schedules shall be supplied in writing unless the carrier makes the fees for included CPT or HCPCS codes available on their website or otherwise makes them available electronically to providers.

1. When a provider is contemplating participating in multiple health benefits plans offered by a carrier and such plans have different fee schedules, the carrier shall provide the complete proposed fee schedule(s) applicable to that provider for each plan in which the provider participates.

2. The carrier shall make available online the name of any commercially available software used by the carrier for editing claims, together with a description of carrier-specific edits in a manner detailed enough to provide an understanding of such specific edits.

(c) All agreements between carriers and participating providers shall meet the following criteria:

1. All agreements shall disclose in plain language the terms and conditions of the agreement, including, but not limited to, the following:

i. Compensation terms, including amount and timing of compensation;

ii. If the agreement applies to products with different compensation or other terms, the specifics applicable to each;

iii. The term or duration of the agreement;

iv. The method(s) by which the contract may be amended, renewed, and terminated;

v. The provider's obligation to participate in preauthorization programs;

vi. The provider's obligation to maintain liability insurance; and

vii. A description of the carrier's internal dispute resolution mechanism.

2. Most favored nation clauses, or clauses having a similar effect, are prohibited.

3. Any agreement that permits unilateral changes shall provide that adverse changes may only be made with sufficient advance notice to permit termination in advance of the effective date of the change.

4. If the terms of an agreement have been the subject of negotiation, no changes shall be made unilaterally to the administration of the contract materially impacting those terms. For example, if rates have been negotiated, carriers may not unilaterally introduce Multiple Procedure Logic or changes to billing requirements that would result in a material reduction in reimbursement for services affected by the change.

5. A carrier shall not make the terms of a provider agreement available to any third party, including, but not limited to, preferred provider

organizations (PPOs), organized delivery systems (ODSs) and such other entities as the carrier may lease networks to, unless:

i. The agreement specifically states that the carrier may enter into an agreement with third parties allowing the third parties to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity;

ii. Every third party accessing the provider agreement is contractually obligated to comply with all of its terms;

iii. The carrier identifies all such third parties in existence as of the date the agreement is entered into;

iv. The carrier includes on its website a listing, updated no less frequently than every 90 days, identifying all such third parties;

v. The carrier requires each third party to identify the source of the discount on all remittance advices and/or explanations of payment under which a discount is taken;

vi. The carrier notifies the third party of the termination of a provider contract upon issuance of the termination by the carrier or upon receipt of notice by the provider;

vii. The third party ceases its right to a provider's discounted rate upon termination of the provider's contract with the carrier.

For purposes of this subsection, "third party" does not include any employer or other group for whom the carrier provides administrative services, including at least the payment of claims; and

viii. Carriers deliver to participating providers a copy of any agreement relied on in the adjudication of a claim within 30 days after the date of a request from the provider.

(d) Any adverse change or amendment during the term of the agreement may be made in accordance with the terms of the agreement only upon 90 days notice prior to the effective date of the change or amendment. If the provider declines to accept the amendment, the provider may terminate the agreement as set forth in N.J.A.C. 11:24C-4.3(c)3.

(e) Agreements may automatically renew. However, no adverse change may be made to the terms of an agreement upon its automatic renewal. Any such change may be made to the agreement as set forth in (d) above either before or after its renewal.

(f) Carriers shall deliver to participating providers a copy of the fully executed initial agreement and any amendments thereto within 30 days after the effective date of the initial or amended agreement, and within 30 days after the date of a request from the provider for a copy of the agreement and/or amendments.

11:24C-4.4 Provider reimbursement

When participating providers are reimbursed on a basis other than fee-for-service (for example, capitation, per diem, or percent of charges), the agreement shall specify the dollar amount or methodology used by the carrier to determine reimbursement, and identify the services included in and excluded from the alternate reimbursement methodology.

11:24C-4.5 Content and availability of provider network directories

(a) Carriers shall maintain accurate and current information on all providers, and make that information available to members and prospective members through network directories, as described in this section.

(b) Directories shall include, at a minimum, the following information on all participating providers: name, gender, office locations, phone numbers, professional designation, specialty, acceptance of new patients, practice limitations, and languages spoken other than English.

(c) Directories shall contain a listing of the carrier's in-network hospital outpatient facilities by the types of services the facilities provide. Where applicable, directories shall also prominently display a statement advising members that not all outpatient service providers located at in-network hospitals are in-network providers, and urging members to confirm whether an outpatient service provider is or is not a member of the network before obtaining services from such provider.

(d) A carrier's electronic directory shall include functions designed to facilitate the ability of members to customize their search for providers. Search functions shall include, but not be limited to, specialty and geographic area.

(e) Upon request, carriers shall provide their current printed directory to members and prospective members of the health benefits plans offered by the carrier. The requirement to supply printed directories upon request may be complied with by printing and mailing the most current version of the on-line directory applicable to a particular member's plan in lieu of periodic publication and stocking of hard copy directories. The carrier shall mail a copy of the printed directory to a member or prospective member within five business days of the request.

(f) If a carrier publishes a hard copy of the directory, the information shall accurately reflect the content of the carrier's electronic directory as of the date the printed directory was submitted for publication. The following information shall be included in or accompany the printed directory:

1. The date of publication of the printed directory;

2. A statement that the directory is accurate as of the date on which the printed directory was submitted for publication;

3. A statement that more current directory information is available on the carrier's electronic directory available on the carrier's website;

4 The anticipated date on which the next printed edition will be published; and

5. The carrier's website address where the electronic directory can be accessed.

(g) Carriers shall maintain a history of their electronic directories for three years. This requirement may be met by establishing a capability of reconstructing a directory as of any date within the prior three years.

(h) Carriers publishing hard copy directories shall retain as business records copies of each version of its printed provider directory for at least three years from the publication date.

11:24C-4.6 Standards for accuracy of provider directory information

(a) Carriers shall implement a system for maintaining accurate and current information on all providers listed in a network directory.

(b) Carriers shall ensure the information in the provider directory is based on the most recently submitted information from the provider or the Council for Affordable Quality Healthcare (CAQH).

(c) Carriers shall update electronic directories within 20 days of the carrier's receipt of confirmation from a provider or CAQH that current information is inaccurate or has changed. When a carrier disputes a notice that information on a provider is inaccurate, the carrier shall, within 15 days of receipt of a notice from a provider or consumer asserting that the

information is inaccurate, respond to the notice in writing and include in its response the reason(s) supporting its position that the challenged information is accurate.

(d) Carriers shall confirm the participation of any provider who has not submitted a claim for a period of 12 months or otherwise communicated with the carrier in a manner evidencing the provider's intention to continue to participate in the carrier's network and for whom no change in provider status has been reported by CAQH. The process for confirming participation shall be as follows:

1. The carrier shall contact the provider and request that the provider confirm his or her intention to continue to participate in the carrier's provider network. Based on the provider's response, the carrier shall update its directories as necessary.

2. If the provider fails to respond to a communication by the carrier, the carrier shall mail a follow-up request to the provider by certified mail, return receipt requested. If the provider fails to respond to such request within 30 days, the carrier shall remove the provider from its network and update its directories as necessary.